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ABSTRACT

The manual describes policies relating to the roles and contributions to special education of occupational and physical therapists. Following a summary of certification requirements, the therapists' roles in a school setting are examined. Conceptual roles are outlined for decision making, program management, liaison, support/resource/consultation, and education. Similarities in the roles of occupational and physical therapists are noted and specific responsibilities for each are discussed. Guidelines are offered to help educators clarify occupational and physical therapy when services are appropriate/needed. A service delivery model is set forth which emphasizes change in functional abilities and rapidity of change. For each of four levels of service, the purpose of intervention, intensity of service, and the personnel responsible for delivery of services are described. Examples of delivery model levels are provided, as are a list of service delivery methods and resource alternatives within the school and the community. Referral procedures are detailed. A section in which assessment and evaluation methods and tools are reviewed is followed by a section on program planning. The final section focuses on documentation and includes sample general administrative forms and discretionary forms. (CL)

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WAUKESHA DELIVERY MODEL

PROCEDURES MANUAL

Providing Occupational/Physical Therapy Services to Special Education Students

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Wisconsin Department of Public Instruction / Herbert J. Grover, State Superintendent

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Waukesha Delivery Model: Providing Occupational/Physical Therapy Services to Special Education Students

A Procedures Manual

"PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY
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Developed by Waukesha County Exceptional Education Cooperative

Printed and Disseminated by Wisconsin Department of Public Instruction

Herbert J. Grover, State Superintendent

EC 200 592

The development of this service delivery model and the resultant manual was partially funded through discretionary funds from PL 94-142 (Project *84-0714-15). The Wisconsin Department of Public Instruction printed and disseminated this guide as a model for consideration by other school districts. This does not constitute an official endorsement by the DPI.

Bulletin No. 7339

Revised March 1987

The Department of Public Instruction does not discriminate on the basis of race, sex, age, religion, handicap, or national origin.

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Foreword

Congratulations to the Waukesha County Exceptional Education Cooperative on the development of an efficient delivery model for providing occupational and physical therapy services to students.

In the Wisconsin tradition, it is significant that school districts have a certain amount of flexibility in how they provide services to children. This allows for the consideration of local conditions.

Wisconsin can be proud of the progress it has achieved in serving children with special needs. Certainly, it is the kind of initiative demonstrated by the Waukesha cooperative that contributes to excellence in Wisconsin education.

Herbert J. Grover
State Superintendent

Preface

Programming for students who need special education may, if needed, include the provision of the related services of occupational therapy (OT) and physical therapy (PT). With the passage of PL 94-142 and Wisconsin Chapter 115, many students are today receiving these related services in order to help them progress in their individual educational programs.

Previously students with orthopedic handicaps received OT and PT services which were provided according to a medical model. Today, using an educational model, school districts are providing these related services to more handicapped students.

Both state and local school administrators have been concerned with how to provide these services in an effective and an efficient manner. The Waukesha Delivery Model is one attempt to most efficiently use professional staff to identify, evaluate, and incorporate into the special education student's Individualized Education Program (IEP) the appropriate amount of therapy service based on the student's current need.

The original proposal funded with discretionary funds from PL 94-142 stipulated that the results of the development of a system for delivery of OT and PT services and the resulting procedures manual would be considered for dissemination by the Wisconsin Department of Public Instruction. It is hoped that this delivery model will assist school districts in assessing the need for the provision of related services to handicapped students.

Acknowledgments

The development of this manual and the resultant system of occupational and physical therapy service delivery was partially funded through discretionary funds from PL 94-142 (Project #84-0714-15).

Ruth A. Kalish, Ph.D., and her associate, Luann Wilkenson, Ph.D., were hired as outside consultants for the project.

Lois F. Latsch, who supervised occupational and physical therapy at the Wisconsin Department of Public Instruction until her retirement in 1985, provided support and guidance throughout the development of this model.

The following occupational and physical therapists, who provide services to students requiring assistance, gave varying degrees of time toward making this project a success. Without their efforts, this project would not have become a reality.

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Occupational/Physical Therapy Philosophy

In compliance with state and federal law, school occupational and physical therapists are *related service personnel* to exceptional education programs. They provide services to individual students and consult with educational staff in assisting a student to benefit from an exceptional educational program. Therapists work to improve, develop, restore, and/or maintain a student's sensory/motor functions as they relate to *the educational setting*. These functions may have been altered or delayed by disease, injury, illness, or congenital defects. Specific types of services are flexible and change, depending on the needs of the student and the educational staff.

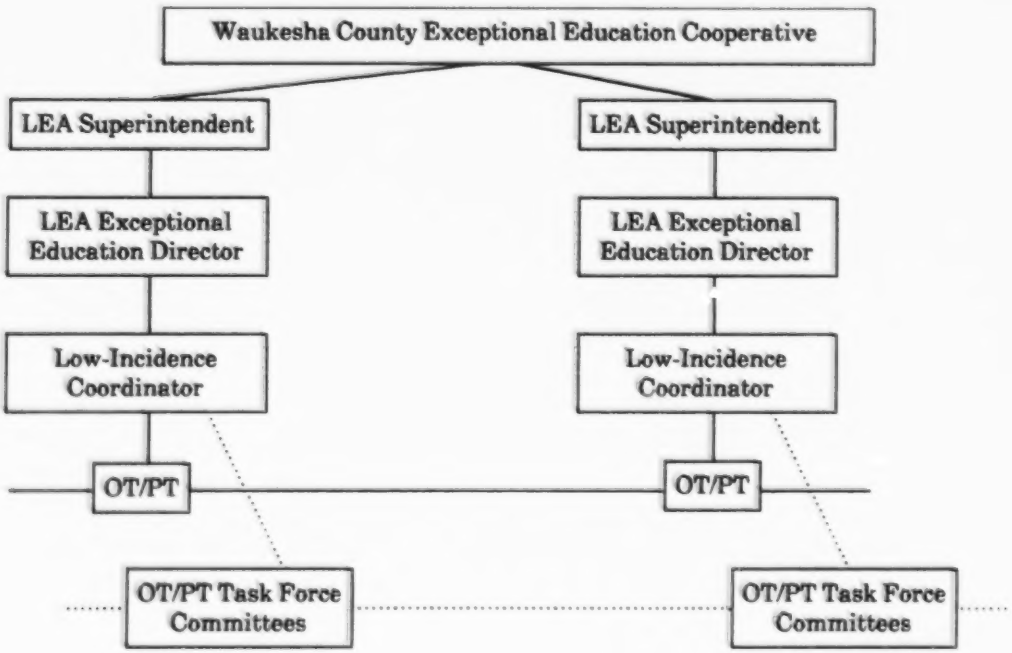
The Waukesha County Exceptional Education Cooperative

Organization

The Waukesha County Exceptional Education Cooperative was formed as a result of a Waukesha County Board of Supervisors decision to dissolve the Waukesha County Handicapped Children's Education Board. The dissolution became effective on June 30, 1982.

While the Waukesha County Handicapped Children's Education Board was in place, it operated regional centers for some of the low-incidence handicapped students in several of its districts. In addition, occupational and physical therapy services were coordinated through the WCHCEB. Several planning committees, one comprised of directors/designees of exceptional education and the other of superintendents, decided to continue to regionalize low-incidence classes and to coordinate occupational and physical therapy services under one administrative structure. As a result, they created the administrative position of low-incidence coordinator.

Organizational Chart



Participating Districts

Elmbrook
Hamilton/Sussex
Hartland/Lakeside
Kettle Moraine
Lake Country Exceptional Education Cooperative
Menomonee Falls
Mukwonago
Muskego/Norway
New Berlin
Norris
Oconomowoc
Waukesha

Qualifications for School Occupational and Physical Therapist Certification

The *occupational therapist* must meet the following qualifications in order to work in Wisconsin public schools:

1. Successfully complete a college program accredited by the American Medical Association and the American Occupational Therapy Association.
2. Successfully complete 6-9 months fieldwork experience.
3. Successfully complete the National Occupational Therapy Association Registry examination.
4. Successfully complete 9 credits in special education.
5. Obtain and maintain a Department of Public Instruction issued license.

The *physical therapist* must meet the following qualifications in order to work in the Wisconsin public schools:

1. Successfully complete a college program accredited by the American Medical Association and/or the American Physical Therapy Association.
2. Successfully complete 4-9 months fieldwork experience.
3. Successfully pass the Wisconsin State Physical Therapy Licensing examination.
4. Maintain a current Wisconsin physical therapy license.
5. Obtain and maintain a Department of Public Instruction issued license.

Therapists' Roles in the School Setting

Occupational and physical therapy services are provided to students whose handicapping conditions interfere with their ability to benefit from special education programming. Therapy services are provided to a wide variety of handicapped students within the age range specified by the Wisconsin Department of Public Instruction. The purpose of both occupational and physical therapy includes restoring or maintaining function; fostering normal development; and, where feasible, preventing further disabilities. In order to meet these objectives, therapists are required to assume a variety of responsibilities and roles.

Conceptual Roles

Occupational and physical therapists assume a variety of responsibilities and roles in the school setting. These conceptual roles include but are not limited to the following:

I. Decision Making

A. Assessing the student to determine present level of functioning
B. Participating in multidisciplinary team decision making
C. Participating in long- and short-term goal planning for the student's Individualized Education Program (IEP)
D. Designing therapeutic programs to assist the student in achieving educational objectives

II. Program Management

A. Obtaining an adequate area for therapy in an assigned building
B. Scheduling students according to levels of service
C. Recommending therapy procedures designed to achieve educational goals established for the individual student
D. Recommending equipment and assisting in procurement of the same
E. Documenting student progress
F. Evaluating the program

III. Liaison

Both therapists act as liaisons between medical and educational systems regarding the student's *physical condition* and its effect on learning and level of functioning.

IV. Support/Resource/Consultation

A. Providing consultative services to classroom teachers and other educational staff relative to the individual student's functional level in the classroom
B. Providing consultative services to parents regarding the student's handicap and its effect on level of functioning at home, school, and in the community,

and assisting in locating community resources when the therapy needed is not required to assist the student to benefit from special education

V. Education

A. Providing inservice training for teachers, teacher aides, administrators, and other educational staff, and parent and community groups as necessary
B. Supervising university students in clinical rotations in occupational and physical therapy programs (optional)
C. Providing staff development

Similar Roles of Occupational and Physical Therapists

The general goal for physical and occupational therapists is the same: to allow the student to succeed within the special educational setting by minimizing the effect of the physical disability or handicapping condition. The therapists' basic role is to organize, develop, and implement a therapy program involving the use of selected, constructive activities. Both work to

- develop physical prerequisites for functional skill development and coordination;
- improve impaired muscle strength and limit the impact of muscle deteriorating diseases;
- improve or maintain physical endurance impaired through physical injury or disease;
- improve functional independence by recommending and teaching use of adaptive equipment and/or teaching other methods of compensation;
- educate staff, students, and families regarding each student's disability, motor potential, use of equipment, and so forth.

Physical and occupational therapists use tests, measurements, and other evaluation procedures to ascertain the student's functional level, gross and fine motor abilities, and sensory/motor abilities in order to establish performance baselines. Both interpret their findings and make recommendations. Each profession uses its own expertise in the structuring, conducting, and interpretation of these evaluations.

Physical and occupational therapists participate in developing and writing Individualized Educational Programs, relating goals in the above areas to the special educational setting. Therapy in the educational setting is intended to develop and maintain a student's physical potential for independence in all educational activities. Therapy is initiated and continued through an annual physician prescription/referral.

Occupational and physical therapists provide related services in the educational setting. They are available to work with, not replace, the educational staff. They are able to provide staff with recommendations and guidance about how best to work with and handle students with handicapping conditions in their classroom, thus providing a "therapeutic day" for their students. Full cooperation among therapists and the educational staff is essential to a student's successful development and positive school experience.

Specific Roles of Occupational Therapists

Roles and responsibilities specific to occupational therapists include but are not limited to the following.

I. Developing prerequisites for fine-motor coordination

   A. Adequate trunk/head control to sit up, attend to teacher, write, and so forth
   B. More normal movement patterns in hands/arms
   C. Appropriate grasp patterns
   D. Full range of motion in trunk/arms

II. Recommending equipment and training a student to use equipment/classroom adaptations to develop self-help, classroom, or hand skills

   A. Dressing aids
   B. Eating aids
   C. Writing/reading aids
   D. Special chairs
   E. Prosthetic devices
   F. Splints

III. Developing sensorimotor skills and sensory integration as necessary for classroom performance (moving about school, writing, reading, playing, dressing)

   A. Developing motor planning (ability to perform an unfamiliar movement)
   B. Promoting bilateral integration (coordinated use of both sides of body)
   C. Reducing tactile defensiveness (abnormal response to touch)

IV. Teaching/helping to develop work simplification and motion economy techniques within the school setting for a student with a debilitating physical condition

Specific Roles of Physical Therapists

Roles and responsibilities specific to physical therapists include but are not limited to the following.

I. Developing prerequisites for gross motor skill development

   A. Automatic balance responses
   B. Trunk control for upright postures
   C. More normal movement patterns in legs and feet
   D. Full range of motion in trunk, legs, and feet

II. Developing mobility, including

   A. Development of independent walking, crawling, and creeping
   B. Use of wheelchairs
   C. Use of assistive devices such as crutches, canes, walkers, adapted tricycles
   D. Use of prosthetic devices

III. Recommending equipment and training a student to use adaptive equipment/ classroom adaptations to enhance gross motor movements

A. Prone standers/standing frames
B. Special chairs
C. Leg braces, splints
D. Other positioning equipment

IV. Consultation with and training of staff in the following areas

A. Handling
B. Positioning
C. Safety/transfers

V. Developing and monitoring programs of respiratory functioning

Occupational and Physical Therapy as Educational Therapy

Occupational and/or physical therapy-related services are provided to handicapped students to help them benefit from the educational process. It is important to identify a student's need for therapy services in the school setting as opposed to the need for therapy in other settings. Therapy services contribute to the development, improvement, or maintenance of the handicapped student's functional level when educational instruction does not in itself provide for necessary remediation.

Related Services

The following guidelines are provided in an effort to clarify for educators and therapists the indication for occupational and physical therapy services in the school setting.

I. **Student lacks normal basis for sensory-motor development:**
Occupational and/or physical therapy services may be necessary when a student demonstrates problems with the prerequisites of motor skill development and coordination. These prerequisites include, but are not limited to, the following:

A. *Muscle tone* provides the ability to assume and maintain positions against gravity, to voluntarily change positions, and to move freely. Muscle tone is necessary for control and coordination of trunk, legs, and arms.

Rationale: Trunk control is necessary for balancing, sitting at a desk, holding up one's head. Head control is necessary to allow a student to attend to the teacher or to read. Arm control is necessary for writing, breaking a fall, dressing, and eating. Leg control is necessary for walking, moving about the school, running, and independent sitting.

B. *Strength and endurance* provide the ability to perform expected physical activities without tiring.

Rationale: Students whose strength or endurance has been limited by disease or chronic conditions may not be able to keep up with peers and may be unable to complete classroom assignments.

C. *Range of motion* is the amount of joint movement.

Rationale: A limited range of joint movement can lead to deformities which interfere with functional use of arms or legs as may be required in the school setting.

D. *Reflexes* are predetermined, obligatory movements to an outside stimulus. One example would be a startled reaction to an unexpected noise.

Rationale: Abnormal reflex activity may interfere with a student's attention to classroom work, ability to sit safely, ability to look at an object he or she is holding (eye-hand coordination), ability to maintain pencil grasp, and therefore general development of motor skills.

E. *Automatic balance responses* provide the ability to maintain and/or regain body position during any movement.

Rationale: Developing balance is necessary for safe sitting, safe walking, and freely changing positions.

F. *Sensory integration* is the organization of sensory input for use. The "use" may be a perception of the body or the world, an adaptive response, a learning response, or movement. Through sensory integration, the many parts of the nervous system work together so that a student can effectively interact with the environment and can learn, move, and experience appropriate satisfaction.

Rationale: A student must understand/organize information from the environment to use it. For example, a student unable to filter out unnecessary touch information may be highly distracted and unable to attend to the teacher. A student unable to learn from past movement experiences may need excessive energy and attention to relearn a simple motor task (such as holding a pencil) and, therefore, may be unable to have time to do seatwork or to learn to dress.

II. **Student lacks functional independence:**
Occupational and/or physical therapy services may be indicated when a student demonstrates problems in performing functional daily living skills owing to a physical/sensory motor deficit.

A. *Mobility* includes any method of purposeful movement used to get from one location to another. It may include rolling; crawling; and using a wheelchair, tricycle, crutches, or other aids.

Rationale: Mobility is important for active participation and for the ability to act on one's environment. It is important for a student to move within the classroom or school building, to allow incidental learning, to help develop perception, to develop self-worth, and to allow a student to assume appropriate age-level responsibilities.

B. *Fine motor movements* include the prerequisites and combinations of movements necessary to be successful and independent in fine motor skills.

Rationale: In order to participate effectively in academic tasks, the student must be able to manipulate classroom equipment such as pencils, scissors, books, or assistive devices. This may include effective reaching, hand grasping, and using both hands.

C. *Gross motor movements* include the prerequisites and combinations of movements necessary to be successful and independent in gross motor skills.

Rationale: Balance, muscle tone, strength, and endurance are important prerequisites for gross motor skill development. These are necessary for a student to walk, run, climb stairs, use playground equipment, and participate in games and physical education.

D. *Self-help functioning* includes the necessary prerequisites and combinations of movements to effectively manage daily living needs such as dressing, eating, and toileting.

Rationale: Students who are able to independently and effectively manage their own needs have a greater opportunity to benefit from educational programming. Effective independence in feeding, dressing, and toileting can allow a student to spend more class time focusing on the development of academic skills. Such independence is also important in the development of self-worth and independent living.

Service Delivery Model

The Service Delivery Model is based on students' educational needs. It is used to plan students' individual educational programs (IEP), based on their physical/functional status and considering their anticipated rate of change. Intensity of therapy services includes contact time with the student as well as time spent on behalf of the student. Various personnel may be involved with the delivery of service.

Perspective

The functional framework for the Service Delivery Model is a useful tool for the therapist or teacher who is seeking to understand the student's educational/therapeutic needs. It emphasizes change in functional abilities and rapidity of change. Each category considers the progression of the medical condition and the related functional status: Is a disease course increasing, decreasing, or stable? Is functional ability increasing, decreasing, or stable? How rapidly is change occurring? Who needs therapy?

The first category includes those students where the effects of the disability are increasing, the disease course is progressing, or functional ability is decreasing. Change may be slow or rapid. In other words, the student is becoming progressively more disabled within an anticipated course of time. Therapy for these students is directed toward maintaining as much function for as long as possible. Levels I and II of the Service Delivery Model include students from this category.

A second category includes those students where the effects of the disability are decreasing and the expected disease course is abating. Again change may be slow or rapid. Therapy for these students is directed toward improving function, as both maturation proceeds and the disease abates. Levels I and II of the Service Delivery Model include students from this category as well.

A third category includes those students where the effects of the disability are neither increasing nor decreasing but are stable. Some of these students may, however, lose function and exhibit increasing disability without therapy. These students are placed in Levels III and IV of the model.

Handicapped students are at different places on the disease course or functional ability continuum. Where the student is on this continuum may have significant implications for the degree or level of therapy services to be provided. Service delivery for therapy must take into consideration

- the disease course;
- the functional status of the student;
- the rapidity of change for both.

The Service Delivery Model, with a variety of levels of service, is designed to meet the needs of the individual student.

Each level of service is associated with a recommended commitment of time per student. These guidelines for intensity of service should be followed except when variations in the educational program or environment temporarily require an adjustment (either up or down) of time commitment. Should the functional status of the student change, a concurrent change in the level of service will be made.

Each level of service is also associated with a varying amount of involvement by the therapist, with other personnel involved as appropriate. Working as a team, they carry out a "therapeutic day" for the student and help achieve the common goals contained in the IEP. This is accomplished by the staff incorporating simple recommendations from the therapist into the student's class day. Therapists and teachers need to work together to understand the student's needs and the classroom routine and set-up; thus they recommend activities accordingly, without placing unrealistic demands on the teacher or the classroom program. Examples of recommended activities may be:

- How best to position a student to perform certain activities. This may be achieved by using specific equipment (a corner chair, standing frame, scooterboard) or by giving verbal cues to the student (keeping head straight, no "W" sitting, reminding student not to switch hand usage and to use both hands when needed).
- How to support a student's arm to allow fine motor tasks to be performed more efficiently or effectively.
- What types of adapted materials may be best for the student for certain activities (for example, built-up pencil, desk easel, typewriter).

Carrying out these recommendations is necessary to provide adequate functioning of the student in the educational setting. When a student's physical/functional status is changing, a therapist needs to be involved on a more regular basis with the student in order to help accommodate for changing needs in the classroom. When the student's status becomes more stable, needs can be efficiently met by other personnel who continue to incorporate the therapist's recommendations into the student's day. Some students may reach maximum benefit from a therapy program; thus, they can be discharged or gradually weaned from services.

It is important to remember that the parents/guardians are also members of the team, and many of the recommendations need to be carried out at home as well, in order to adequately enhance the student's physical/functional status.

Service Delivery Model

All students receiving occupational/physical therapy services are assessed and assigned one of four levels of service. The levels of service are based on the rate of change in the student's physical/functional status and may change during the school year. Each level of service defines the purpose of intervention, intensity of service, and the personnel responsible for the delivery of services. Therapists are involved in evaluation, therapy service planning, parent/staff training, and monitoring of student's programs.

Level	Physical/Functional Status of Student	Purpose of Intervention	Intensity of Service	Therapist/Staff Involvement
I	Student is undergoing rapid and/or crucial change in physical/ functional status.	Therapy goals are designed to develop functional level or prevent significant regression.	Time commitment may range from 2½ – 3½ hours per week; of that, 2/3 is targeted on time with student, 1/3 is targeted time on behalf of student. Therapy revisions are frequent.	Physical needs are primarily addressed by the therapist by providing specific therapy techniques, with other personnel involved as appropriate in order to provide a "therapeutic day."
II	Student is undergoing moderate change in physical/functional status.	Therapy goals are designed to develop functional level.	Time commitment may range from 1½ – 2½ hours per week; of that, 2/3 is targeted as time with student, 1/3 is targeted time on behalf of student. Therapy revisions are periodically necessary.	Physical needs are addressed by the therapist by providing specific therapy techniques, with other personnel involved as appropriate in order to provide a "therapeutic day."
III	Student's physical/ functional status is undergoing some change or is stable.	Therapy goals are designed to develop and/or maintain functional level.	Time commitment may range from ½ – 1½ hours per week; of that, 2/3 is targeted as time with student, 1/3 is targeted time on behalf of student. Therapy revisions are infrequent.	Therapist is now in a more supportive role, with other personnel involved as appropriate in order to provide a "therapeutic day."
IV	Student's physical/ functional status is stable.	Therapy goals are designed to monitor functional and physical status.	Time commitment is up to 20 hours per school year. Contact frequency may vary (bimonthly, monthly, quarterly). Student may be placed on Level IV to monitor status prior to dismissal.	Therapist will monitor on a needs basis, providing input on student's needs as appropriate. Other personnel may need to continue to follow through on simple recommendations in order to help maintain the student's physical/ functional status.

Assigning or Changing a Service Level

I. Assigning a Level of Service

A. Upon qualifying for OT or PT related services, the therapist recommends a level of service to the IEP Committee, based upon the physical/functional status of the student.

B. The recommended level of service should be discussed with the school personnel and the parents at the IEP conference in terms of the student's physical/functional status; purpose of therapeutic intervention; and, if appropriate, the intensity of programming.

C. The assigned level of service should be communicated to the low-incidence coordinator on the Add/Delete/Change (ADC) Form (see p. 45). This information should be included on the therapist's student list.

II. Changing a Level of Service

A. Changes in an assigned level of service may be recommended by the therapist, based upon changes in the student's physical/functional status.

B. These changes will involve an IEP revision.

C. Changes in level of service should be communicated on the ADC form to the low-incidence coordinator as they occur. This information will be updated on the therapist's student list.

III. Dismissal

If a student is being considered for dismissal from OT or PT related services, an M-Team meeting must be held.

Examples of Delivery Model Level Students

I. Level One

- Young student (3-5 years old) with cerebral palsy and receiving Early Childhood services. The student is new to the school system and continues to show significant functional changes in ambulation and mobility skills with therapy (example: child has just begun to walk).
- Student receiving learning disability programming with a progressive neurological disorder of unknown cause. This student has been mainstreamed into a regular classroom and is undergoing crucial functional changes in the following areas: (1) loss of head control necessary for visual attending to classwork, (2) loss of independent sitting balance at desk, (3) loss of hand skills, and (4) loss of independent mobility.

II. Level Two

- Elementary grade student in a learning disability program who has cerebral palsy (hemiplegic). With therapy, the student continues to show steady functional gains in the following areas: (1) bilateral hand skills (cutting, manipulating clothing fasteners, ball catching), (2) self-care, (3) gross motor coordination (example: child can climb stairs).
- A young, developmentally delayed student receiving programming in early childhood. This is the "clumsy" student, who, with therapy, continues to make gains in the motor prerequisites (such as basic functional balance, weight shifting, postural control) necessary for skills development. Problem areas seen in the classroom may be poor attention span, distractability, poor desk posture, motor planning problems (poor organizing of work, following directions, cutting, coloring) and awkwardness in gross motor movements compared to other students of the same age.

III. Level Three

- Student with spina bifida receiving specially designed physical education. This student has essentially reached a plateau in development skills (head control, sitting ability, mobility); however, the potential exists for physical regression (increasing muscle tightness, dislocated hip, skin breakdown) which could interfere with classroom programming without regular supportive input from a therapist.
- Student with spina bifida who has become functional within the school setting. The student's physical status and cognitive level is age appropriate, but student continues to need intervention to improve on quality and endurance in these skills and to enhance other skills during growth and maturation (examples: stair climbing, bus transferring, toileting).

IV Level Four

- Middle or high school student receiving special education services. Owing to years of previous therapy, this student's physical/functional status has stabilized or reached a plateau. Therapy intervention is necessary to monitor status and/or equipment to ensure that classroom needs are being met.
- Student receiving specially designed physical education. This student displays delayed gross motor skills and poor quality of movements compared to other students of same age; however, the student has had several years of therapy, with the physical/functional status reaching a plateau. Mental retardation, behavior problems, and/or poor cooperation may be interfering with further progress. School personnel are familiar with incorporating appropriate therapy-related techniques into classroom program. Student may be placed on Level IV to monitor status prior to dismissal.

Methods of Service Delivery

I. *Contact Time*: Time spent providing the following services to enhance a student's special educational program. *The student must be present.*

A. Evaluation—the individualized, detailed, and documented assessment of a student known to have or suspected of having an educationally handicapping condition
   1. New referrals
   2. Re-evaluations of students presently on caseload

B. Therapeutic intervention—implementation of OT/PT programs
   1. Student therapy session
   2. Classroom observation of student
   3. Teacher, staff, parent consultation, with student present
   4. Positioning, fitting, or adjusting adaptive equipment
   5. Home visit
   6. Hospital or clinic visit with student

II. *"On Behalf of" Time*: time spent on the following student-related activities. *The student is not necessarily present.*

A. Program planning and preparation
   1. IEP conference and revisions, as necessary
   2. Therapy planning based on IEP
   3. Preparing materials
   4. Ordering or making of adaptive equipment

B. Report writing
   1. Initial evaluation, annual report, or re-evaluation
   2. Progress notes
   3. Home programs
   4. Letters to physicians or to other agencies

C. Communication
   1. Phone calls related to student services, i.e., parent, physician, wheelchair service
   2. Multidisciplinary Team meetings
   3. Informal staffing conferences

III. *Preparation Time*: Time spent on job-related activities other than contact or "on behalf of" time. *Therapist has no contact with student.*

A. General classroom observation and teacher consultation regarding possible student referrals
B. Record keeping, i.e., attendance, monthly data sheets
C. Scheduling
D. General equipment and supply upkeep (not student specific)
E. General staff inservice and department meetings

F. Phone calls and written documents concerning the above

Resource Alternatives

Resource alternatives are possible adjuncts to the therapy service or, if no therapy service is indicated, as part of the student's educational program.

I. Within the School Setting

A. Teacher
B. Teacher aide
C. Other students in class
D. Regular education students
E. Adult volunteer, room parent
F. Physical education program (regular, adaptive, specially designed physical education)
G. Parent-teacher organization

II. Within the Community

A. Parents, family members
B. Therapy services through local hospital, rehabilitation centers, private therapy, etc.
C. Physicians (to monitor progress or changes)
D. Volunteers (foster grandparent, big brother/big sister program, PTO, etc.)
E. Community recreation programs (summer camp, YMCA, swimming program, etc.)
F. Local or state associations (United Cerebral Palsy, Association for Retarded Citizens, Muscular Dystrophy Association, Visiting Nurse, etc.)

Referral Procedures

Students may be referred for occupational or physical therapy by teachers, parents, therapists, physicians, members of an IEP team, or any other interested person. An OT/PT Teacher Checklist (see p. 20) may be used by teachers considering a referral or by teachers and therapists to open discussion of a particular student already in therapy.

Initiation of evaluation requires a physician prescription form and parental permission for assessment.

Referral Procedures

Occupational/Physical Therapy

1. Referral is completed and sent to district's special education office, or office designated for receipt of referrals.

2. The case manager or special education office obtains the necessary parent consent for the Multidisciplinary Team process and the medical information (prescription).

3. Upon receipt of the prescription and the parental consent, the case manager or special education office calls the low-incidence coordinator for a therapist assignment. The following information should be provided to the low-incidence office:

   - Student name
   - Home district
   - School attending
   - Date of referral
   - Date of prescription
   - Date of parent consent
   - Suspected EEN areas
   - Name of case manager/telephone number

4. Assignments are made by the low-incidence coordinator. This assignment process ensures that reasonable evaluation loads are maintained for each therapist. Efforts are made to assign building/district personnel whenever possible. If it is determined by the low-incidence coordinator that a district therapist is unable to conduct an evaluation at the time of request, an alternative therapist will be assigned. The therapist/districts involved will be informed in writing of the assignments. Proper notice is provided to the parents of any change in evaluation staff.

5. After being notified of the assignment and name of the case manager, the therapist contacts the case manager for referral data.

6. Upon receipt of the referral data, the therapist:

   - Reviews the prescription for completeness of information. If further medical information is required, the therapist will obtain it.
   - Performs an evaluation of the student and completes a report of the findings (see pp. 34-35).

7. After the evaluation procedure is completed, the therapist notifies the case manager.

8. The case manager notifies the therapist of the Multidisciplinary Team date. The therapist attends the M-Team meeting, and if needed, subsequent IEP meeting.

9. Upon determination of a need for occupational and/or physical therapy services, the district special education office shall contact the low-incidence coordinator for assignment of a therapist. The therapist shall be notified in writing of the assignment.

10. If a student *will not* receive services from a therapist, the therapist is to notify the low-incidence coordinator so that the student can be removed from active status in the referral log.

11. If a student *will* receive services from a therapist, the therapist shall complete an ADC (Add/Delete/Change) Form (see p. 45) and submit it to the low-incidence coordinator's office within two weeks of the initiation of services. These data will be used to update the appropriate student list.

Written permission must also be obtained at this time to authorize release of the therapy evaluations and other pertinent information to the physician(s) named by the parents.

■ Sample Form

Occupational/Physical Therapy Teacher Checklist

Waukesha County Exceptional Education Cooperative

Purpose:
1. To assist school personnel in making a decision regarding an OT and/or PT referral
2. To assist the therapist in gathering information prior to or during an evaluation
3. To assist the educational team in developing the IEP.

Procedure: The teacher completes this form prior to or in conjunction with a therapy referral or evaluation. The therapist(s) may assist the teacher in completing this form, or may review it with the teacher after completion.

Student's Name _____ DOB: _____ Age: _____

Parent/Guardian Name: _____ Home Phone: _____

School: _____ Grade: _____ Home District: _____

Form completed by: _____ Relationship: _____ Date: _____

Has student previously received: Occupational Therapy _____ Physical Therapy _____

Where: _____ When: _____

Is there a diagnosed physical handicap? _____ What? _____

_____

Is student currently receiving Exceptional Education Services? Yes _____ No _____

If yes, please check:
_____ Emotional Disturbance _____ Learning Disability
_____ Mental Retardation _____ Hearing Impaired
_____ Vision Impaired _____ Speech/Language
_____ Early Childhood _____ Physically Handicapped
_____ Specially Designed Physical Education

Are referrals to any other special education programs being considered? _____

If so, what? _____

_____

Estimate cognitive abilities/mental age (may use IQ, if known) _____

Academic Levels: Reading _____ Math _____ Spelling _____

 Student Name: _____

Do you know of any factors which may interfere with development and education performance?

Examples: _____ Visual defect _____ Seizures

_____ Medications (please list if known) _____

_____

_____ Hearing loss; chronic ear infections

_____ Uses adaptive equipment such as wheelchair, crutches, adaptive feeding tools

_____ Other (please list) _____

_____

Please check any of the following statements which are applicable to this student:

GROSS MOTOR/AMBULATION:

_____ Difficulty managing stairs

_____ Unusual walking or running pattern

_____ Reluctant or unable to use playground equipment, participate in games or gym class

_____ Cannot move around school independently

_____ Consistently uses poor posture (sitting at desk, floor; walking)

_____ Falls frequently

_____ Bumps into things, falls out of chair

_____ Appears weaker than peers

_____ Difficulty keeping up with peers, tires easily, has low endurance

_____ Unable to organize body to complete a task or move through a sequence (clumsy, jerky, awkward)

Please describe or expand on these items:

 Student Name: _____

FINE MOTOR/HAND SKILLS:

_____ Doesn't automatically assist with other hand (e.g., to hold paper when writing, to zip clothing)

_____ Difficulty manipulating classroom objects (e.g., blocks, toys, puzzle pieces, pegs, books)

_____ Awkward/poor pencil grasp

_____ Uses whole hand/fist to pick up objects (doesn't pick up items with fingers or fingertips)

_____ Lack of established hand dominance past 6 years of age

_____ Cannot manipulate scissors to cut

_____ Difficulty making smooth lines

_____ Difficulty controlling pencil pressure (e.g., lines too dark or too light)

Please describe or expand on these items:

SELF-HELP SKILLS:

_____ Needs assistance with taking off/putting on clothing (consider age appropriateness)

_____ Needs assistance with toileting (consider adjusting clothing, fastening clothing, getting on and off toilet)

Needs assistance with: _____ Buttons _____ Zipper

_____ Snaps _____ Tying shoes

_____ Opening lunch box

Has difficulty with: _____ Finger feeding _____ Using a fork or spoon

_____ Opening a milk carton _____ Drinking from a glass

_____ Drinking with a straw

Please describe or expand on these items:

 Student Name: _____

SENSORY/BEHAVIOR:

_____ **Overreacts to touch or physical contact; student may hit, may withdraw from, or may crave touch**

_____ **Fearful of movement (e.g., swing, merry-go-round, slide, jumping)**

_____ **Avoids crowded areas (gym, seeks end of line)**

_____ **Tends to touch every object he/she sees**

_____ **Avoids unfamiliar textures (paste, fingerpaint, play-dough)**

_____ **Overly sensitive to sounds; dislikes sound in gymnasium**

_____ **Difficulty learning new motor skills, routines**

_____ **Distractible/impulsive/hyperactive**

_____ **Tends to repeat directions to self**

_____ **Marked mood variations, outbursts, tantrums, silliness, excuses**

_____ **Difficulty with visual perception (e.g., copying shapes, letters, numbers, discriminating colors, shapes, letters)**

_____ **Doesn't visually attend to work/to instructor**

_____ **Poor understanding of directional concepts (up, down, under, over, etc.)**

Please describe or expand on these items:

OT/PT Teacher Checklist (page 5) Student Name: _____

How does student's performance differ from his/her peers? (Consider academic, motor, self-help areas)

How do problems checked interfere with such things as classroom activities, routines, and work?

What methods have been tried to remediate the problems listed? Have they been successful?

Physician Prescription/Referral

A Physician Prescription Form completed by the student's primary physician (either an M.D. or D.O.) is required on an annual basis for each student in the occupational/physical therapy services program in Waukesha County.* A physician's prescription sanctions evaluation and service; it does not mandate it in the school setting. It is the responsibility of the referring district to request the initial prescription from the physician. The determination of therapy services should not be made by the physician; it will be determined as a result of the total Multidisciplinary Team findings. Two documents (see pp. 26-27) should be used to acquire the physician prescription: Cover Letter to Physician for Prescription/Referral and Prescription Form (PI-2127).

The physician prescription must be renewed on an annual basis. The low-incidence office is responsible for obtaining updated prescriptions. Parents are contacted in writing, and follow-up occurs throughout the late spring and summer months. Therapy sessions cannot be provided to the student without this update.

*This requirement is also stated in the Rules Implementing Subchapter IV of Chapter 115, Wisconsin statutes PI-1119(7)(b)(4):

> "The physical therapist shall have adequate medical information and medical prescription from a licensed physician on the appropriate division form before a child is enrolled in the program. There shall be a reciprocal exchange of medical and social information between the division and local professional personnel who are concerned with the child's school placement and total health needs. The district shall obtain an updated medical prescription and information yearly or more often if there is a change in the child's physical condition, e.g., surgery, casting, etc."

■ Sample

Cover Letter to Physician for Prescription Form

[Date]

Dear Dr. [ ]

Enclosed is a Prescription Form for your patient, [Name], who has been referred for occupational and/or physical therapy evaluation and/or service in the Waukesha County Exceptional Education Program.

Any student with a disability who is served in a special education program may be eligible for therapy services. The need for these educationally related therapeutic services must be determined once evaluation has been completed in a meeting of a multidisciplinary team convened to plan for the student's educational program.

Please return the form to the address on the upper right corner of the form. Thank you very much.

Sincerely,

Encl:

Prescription Form PI-2127

D P I Wisconsin Department of Public Instruction
Occupational and Physical Therapy
Physician Prescription
PI-2127 (Rev. 10-86)

INSTRUCTIONS: Complete and return to:

PHYSICIAN: Copy of detailed examination may be substituted for medical information.
THERAPIST: For prescriptions for therapy services, attach copy of your evaluation.

Student's Name	Birthdate: Mo./Day/Yr.	Sex ☐M ☐F	Parent's Name	
Address	City		Zip	County
Date of Last Exam: Mo./Day/Yr.	Diagnosis			

Etiology

Significant Findings on Physical Examination

Pertinent Medical Information, e.g., precautions, surgery, medications

EVALUATION ONLY: Check box to indicate evaluation prescribed. For evaluation/reexamination, refer to reverse.

☐ Occupational Therapy ☐ Physical Therapy

THERAPY: Indicate therapy service prescribed and explain goals.

Occupational Therapy:

Physical Therapy:

Additional Comments

Physician's Name: Type or print	Address	
Physician's Signature ▶ M.D.	Date Signed: Mo./Day/Yr.	Telephone: (Area) No.

(over)

THERAPIST OR PHYSICIAN EVALUATION
Check as appropriate

Neurodevelopmental Problem

☐ Abnormal Muscle Tone Type _____ Severity _____

Distribution _____

☐ Abnormal or Primitive Reflexes

☐ Abnormal Movement Patterns (e.g., scissoring of LE, pronated forearms, fisted hands)

☐ Delayed or Absent Righting and Equilibrium Reactions

☐ Delayed Motoric Ability (e.g., delayed head control, lack of independent locomotion, inability to maintain antigravity positions)

☐ Other Specify _____

Orthopedic and Other Neurological Conditions

☐ Decreased Range of Motion

☐ Right Upper Extremity ☐ Left Upper Extremity

☐ Right Lower Extremity ☐ Left Lower Extremity

☐ Decreased Strength

☐ Right Upper Extremity ☐ Left Upper Extremity

☐ Right Lower Extremity ☐ Left Lower Extremity

☐ Other Specify _____

Functional Impairments

☐ Impaired Ability to Move About

☐ Impaired Functional Living Skills (e.g., feeding, dressing, toileting)

☐ Other Specify _____

Sensorimotor Disturbance

☐ Difficulty with Spatial Relationships

☐ Difficulty with Motor Planning (ability to perform non-habitual movements)

☐ Tactile Hypersensitivity

☐ Difficulty with Bilateral Movements (e.g., crossing midline)

☐ General Incoordination

☐ Other Specify _____

Signature	Title	Date Signed Mo./Day/Yr.
▸		

ASSESSMENT

Assessment entails occupational/physical therapy evaluation of students to determine fine and gross motor abilities and functional ability within the school setting. Assessment may include observation, testing, and a review of records.

Each individual therapist will schedule evaluations with students and their teachers as appropriate. The assessment process shall not begin until the Physician Prescription From and parental permission for assessment are on file in the district office. Previous OT/PT and medical records should also be requested for review before the assessment is begun.

The evaluation process should, when appropriate, involve observation of the student in the classroom as well as during motor activities. Therapists in the Waukesha County Exceptional Education Cooperative use a variety of motor skill, developmental, and standardized performance tests. A brief description of most frequently used assessment tools follows in this section.

Following completion of the evaluation, the therapist is responsible for providing a written summary of the evaluation and making recommendations to the multi-disciplinary team. Guidelines for recommendations have been developed to assist the therapist with this process. Re-evaluation is required every three years.

Evaluation Methods

The choice of evaluation method is determined by the therapist based upon the reason for the therapy referral and an assessment of the student's problems. Information can include the findings gathered from a review of past information (medical records, school file); interviews with the student, family, teacher, and other persons involved with the student; and observations of the student within the school environment. The therapy evaluation describes how the student is performing, why he or she performs in such a manner, and how that interferes with his or her educational programming.

The therapy evaluation may involve the use of:

- Inventories or checklists
- Nonstandardized measurement assessments
- Standardized tests
- Review of records

In most instances a student with motor development problems cannot be put into specific test categories because of many variables. Most standardized tests do not allow for deviation in test administration or scoring as may be needed for a student with multiple handicaps. Often inventories, checklists, and nonstandardized tests are used for a more accurate picture of the student's performance level or physical/functional status.

Frequently Used Evaluation Tools

The following list includes evaluation tools used primarily by occupational and/or physical therapists.

De Gangi - Berk Test of Sensory Integration (TSI) (ages 3-5 years). Measures three subdomains of sensory integration: postural control, bilateral motor integration, and reflex integration. Used to identify children with delays in sensory, motor, and perceptual skills.

The Erhardt Developmental Prehension Assessment (EDPA) (ages 0-6 years). A series of protocol sheets which evaluate prehension through developmental sequence clusters. It looks at transitional skills as well as pattern components which lead to final skills.

First Assessment. A form on which to record clinical observations of a child's reflex activity, motor patterns, physical state, and pertinent personal information.

Hughes Basic Gross Motor Assessment (BGMA) (ages 6-12 years). A standardized test of gross motor functioning based on performance of normal students. Norms are included for the special education population as well. Evaluates gross motor abilities considered basic to the development of higher-level skills. Scoring is detailed to assess the quality of movement.

Miller Assessment for Preschooler (MAP) (ages 2 years, 9 months - 5 years, 8 months). Tests a child's developmental status with respect to other children of his/her age. It specifically tests basic motor and sensory activities, complex fine and oral motor abilities, cognitive language abilities, cognitive nonverbal abilities, and skills requiring an interaction of sensory, motor, and cognitive abilities.

Peabody Developmental Motor Scales (ages 0-7 years). A criterion based checklist of gross and fine motor skills based on normal sequential developmental milestones. Five criterion, ranging from total dependence to complete independence in performing tasks are provided for rating child's performance on each item.

The Revised Gesell Developmental Schedules (ages 4 weeks to 3-4 months). Provides behavioral assessments in the areas of adaptive, gross motor, fine motor, language and personal-social behavior in an attempt to identify even minor deviations in children and to determine the maturity and integrity of the central nervous system.

Southern California Sensory Integration Tests (SCSIT) by Ayres (ages 4-10 years). Tests a child's sensory integration through the assessment of the following: space visualization, figure-ground perception, kinesthesia, manual form perception, finger identification, graphesthesia, localization of tactile stimuli, double tactile stimuli perception, motor accuracy, imitation of postures, crossing midline of body, bilateral motor coordination, right-left discrimination, standing balance with eyes open, standing balance with eyes closed, design copying, and position in space.

Test of Visual Perceptual Skills (TVPS), by Morrison and Gardner (ages 4-13 years). A non-motor assessment of a child's visual-perceptual skills. Results give perceptual quo-

tient, percentile, and median perceptual age on the following subtests: visual discrimination, visual-spatial relationships, visual form constancy, visual figure-ground, visual memory, visual closure, and visual sequential memory.

The following evaluation tools are those which are often used by other disciplines, as well as by therapists, although results may be analyzed from different perspectives.

Brigance Diagnostic Inventory of Early Development (ages 0-7 years). Determines developmental or performance level in the following skill areas: fine and gross motor, self-help, speech and language, general knowledge and comprehension, and early academics. Identifies areas of strength and weakness and instructional objectives.

Bruininks-Oseretsky Test of Motor Proficiency (ages 4 - 14 years). Gross and fine motor subtests which include running speed, control, and upper limb speed and dexterity.

Developmental Test of Visual Motor Integration (VMI), by Keith E. Beery and Norman A. Buktenica (2 forms: A—ages 2-8 years; B—ages 2-15 years). Tests of integration of visual perception and motor behavior in children.

The Motor Free Visual Perception Test (MVPT), by Colarusso and Hammill (ages 4-8 years). A test of visual perception which avoids motor involvement. There are 36 possible responses categorized in areas of spatial relationships, visual discrimination, figure-ground, visual closure, and visual memory.

The Revised Tests of Motor Impairment, by Stotts, Moyes, Henderson (ages 5-12 years and upwards). Assesses motor functioning in the areas of manual dexterity, static balance, dynamic balance, and ball skills.

Recommendations for Services

After the usual formal evaluations and assessments have been completed, the following should be considered when making recommendations:

Rules Implementing Subchapter IV of Chapter 115 [PI 11.19(6)]:

> (6) SERVICE CONSIDERATIONS. (a) Any child who has been determined by the M-team to have EEN shall be eligible to receive physical therapy or occupational therapy or both services upon medical recommendation as stipulated in PI 11.05(2)(e) 7. Any child who has a congenital or acquired disease or condition of such severity that achievement or normal growth and development may be hindered shall be eligible to receive physical therapy or occupational therapy or both services upon medical recommendation as stipulated in PI 11.05(2)(e) 7.

In making recommendations regarding therapy services, the following questions may be helpful.

Educational Need for Service

Expected Response to Therapy Service

- Would therapy be expected to contribute to achievement of the student's overall educational goals or maintenance in the least restrictive environment?

- Has the student received previous therapy? Has the student plateaued? Has the student maintained maximum level of expected functioning without frequent intervention?

- Does the student have perceptual, physical or sensory integrative deficits which interfere in varying degrees to the achievement of academic, motor, or self-help/mobility skills?

- Does the student have a degenerating condition which currently requires some degree of intervention to maintain maximum functioning?

- Does the student need some degree of indirect services such as consulting with teachers, parents, and others; setting up school/home programs; and evaluating for adaptive equipment?

- Would therapy be anticipated to contribute to the achievement of overall educational goals?

Possibility of Needs Being Met by Other People

- Can the student's needs be met by others such as parents, teachers, another school therapy (occupational, physical, or speech), another therapist in the community, or without additional help?

- Does the student's educational instruction already provide for the necessary remediation of the handicapping condition? Examples include:
  - —Speech program includes feeding and oral-motor remediation.
  - —Classroom instruction covers the needed perceptual, gross motor, and fine motor needs.
  - —Student's physical education programming covers the needed gross motor, motor planning and perceptual needs.

Behavior/Cooperation/Motivation

Behavior may be the primary factor influencing a student's performance while the physical disability is only secondary at this particular time.

- Does the student's behavior/cooperation/motivation consistently prevent therapy from being beneficial? Should therapy be discontinued until the behavior problem is alleviated?

- Is there another staff member or parent who has better rapport with the student whom the therapist could consult in order to provide some appropriate therapeutic intervention?

Motor Skills Compared to Cognitive Functioning

- Are the student's gross and fine motor levels commensurate with his cognitive level, maturational age, and other skill levels? If motor level is commensurate or above, then therapy is probably not warranted. If motor level is below other areas, then therapy may be warranted.

■ Suggested Format and Content Outline

Occupational/Physical Therapy Evaluation Report

Name _____ Date of Birth _____ Age _____

Parent/Guardian _____ Phone No. _____

Street _____ City _____ Zip _____

School _____ Grade _____ Home District _____

Referring Physician _____

Physician's Diagnosis _____

Date of Evaluation _____

I. Background Information

A. Reason for referral
B. Significant data (observation from school personnel regarding problems within the educational environment, cognitive functioning and date of last psychological report, if applicable, parent information, and information from other related service)
C. History
   1. Medications, seizures, recent surgery, physician's precautions or recommendations
   2. Previous OT/PT service in school (comment on length of time seen and progress rate, if available)

II. Evaluation

A. Assessment tools used (list)
B. Behavior during testing (including reaction to separation, length of attention span, distractability)
C. Evaluation results (includes scores, age level abilities, descriptions of quality of movement)
   1. Muscle tone and abnormal reflex activity as it related to function (i.e., hyperextensibility of joints)
   2. Equilibrium/balance reactions (i.e., neck righting, protective extension, tilting reactions)—comment on completeness of reactions
   3. Motor patterns (includes coordination and gait)
   4. Muscle strength and range of motion relative to function (manual muscle test or range of motion chart can be attached if there are numerous scores)
   5. Fine and gross motor skills
   6. Perceptual motor skills
   7. Sensory integration

8. Activities of Daily Living (ADL)
   a. Feeding
   b. Dressing
   c. Grooming/hygiene
   d. Mobility (i.e., transfers, toileting, wheelchair)
   e. Communication
9. Adaptive equipment
   a. Wheelchair—modifications and needs
   b. Classroom adaptations
   c. Orthotics
10. Pre-vocational testing
11. Other
   a. Respiratory concerns
   b. Prosthetics

III. Interpretation

A. Evaluation results as related to function in the educational environment

IV. Summary

A. Short statement concerning benefits of OT/PT service or how others might fulfill this student's needs.

PROGRAM PLANNING

Once an assessment is completed and an Occupational/Physical Therapy Evaluation Report is written (see pp. 34-35), the therapist is responsible for participating in the multidisciplinary team (MDT) meeting. The team identifies the student's needs and makes educational recommendations. An Individual Educational Program (IEP) meeting is scheduled at which time a specific statement of program goals and objectives will be made. If occupational and/or physical therapy services are recommended, the therapist(s) will be a member of the team in the development of these goals and objectives. At the time of IEP writing, the level of service is determined as a result of the goals and objectives outlined. To determine the level of service, the following factors should be considered:

- the student's potential to benefit from therapy
- particular staff required to meet the student's needs
- the student's other programming/time commitment needs

Following the IEP meeting, the Multidisciplinary report and the IEP are forwarded to the placement officer. The placement officer will accept or adjust the team's recommendations in accordance with due process procedures.

The Individual Education Plan (IEP)

Public Law 94-142 requires that an IEP be established for each exceptional student who needs special education. A planning conference shall occur prior to a student's placement in a new special education program or when services are added or changed. The goals are revised and updated at least annually. The special education teacher designated as having the primary responsibility for the student's program shall be responsible for coordinating the IEP team, including therapists. This team shall be responsible for development and revision of the IEP.

The following components shall be included in the IEP:

- A statement of student's present level of educational performance which may include academic achievement, social adaptation, motor skills, and self-help skills.
- A statement of annual educational goals based on the needs established by the Multidisciplinary Team.
- A statement of educational objectives.
- A statement of the specific special education and related services to be provided as well as the amount of regular education participation.
- The projected dates for the initiation of services and their anticipated duration.
- Objective criteria and evaluation procedures to determine if the goals/objectives have been met.
- Indication of persons responsible.

Annual goals describe desired progress to be made over a one-year period. They delineate the major areas of focus in a student's educational program. Objectives describe the intermediate steps which need to be obtained in order to reach the annual goal. They are

written in measurable terms and reflect the accomplishments desired of the student over a specified period of time. The following questions should be addressed in developing objectives.

- Who is the learner?
- What is the observable behavior?
- Under what conditions will the behavior occur?
- What are the criteria for success expected of the learner?
- What is the anticipated date by which objectives will be accomplished?

Examples of annual goals are:

- James will improve his mobility about the classroom and school.
- Susan will improve her self-help skills.

Examples of objectives are:

- When provided with his walker and leg braces, James will walk 25 feet within 3 minutes using a 3-step pattern (advance walker, advance right foot, advance left foot) on 4 of 5 observed trials.
- Given a button hook, Susan will button the 4 front buttons on her blouse within 5 minutes of starting the task.

DOCUMENTATION

The process of documenting referrals, initial evaluation, and therapeutic services for each student in the therapist's student list has been described in previous sections. A form is included in this section (see p. 39) to assist the therapist in checking the completeness of each student file and in providing updated student data to the low-incidence coordinator. The form contains demographics on each student as well as dates relating to when information was obtained or level of service assigned.

The therapist is responsible for maintaining complete student records and a weekly schedule. These documents are essential to proper budgeting and planning by the low-incidence coordinator and are to be reviewed on a regular basis. The weekly schedule is also essential for school personnel and parents who wish to locate the therapist at any given time during the week. Several forms are provided for these administrative purposes.

The low-incidence coordinator is to hold a monthly meeting of all physical and/or occupational therapists. Attendance is required. The purpose of the meeting is the outlining and updating of cooperative processes and procedures, inservice training, and professional problem solving.

Sample Form ■

Student Data Collection Form

Student _____ D.O.B. _____ Phone _____

Address _____ Parent _____

School _____ Teacher/Room _____ Grade _____ EEN _____

Physician _____

1. Referral Date _____
2. Consent for Evaluation Date _____
3. Prescription/Medical Referral Date _____
4. Evaluation Date _____
5. Most Recent 3-Yr. M-Team _____
6. IEP Date _____
7. Level of Service Assignment Date _____
8. Change in Level of Service Date _____
9. Home Program _____
10. Classroom Recommendations _____

Student _____ D.O.B. _____ Phone _____

Address _____ Parent _____

School _____ Teacher/Room _____ Grade _____ EEN _____

Physician _____

1. Referral Date _____
2. Consent for Evaluation Date _____
3. Prescription/Medical Referral Date _____
4. Evaluation Date _____
5. Most Recent 3-Yr. M-Team _____
6. IEP Date _____
7. Level of Service Assignment Date _____
8. Change in Level of Service Date _____
9. Home Program _____
10. Classroom Recommendations _____

Student _____ D.O.B. _____ Phone _____

Address _____ Parent _____

School _____ Teacher/Room _____ Grade _____ EEN _____

Physician _____

1. Referral Date _____
2. Consent for Evaluation Date _____
3. Prescription/Medical Referral Date _____
4. Evaluation Date _____
5. Most Recent 3-Yr. M-Team _____
6. IEP Date _____
7. Level of Service Assignment Date _____
8. Change in Level of Service Date _____
9. Home Program _____
10. Classroom Recommendations _____

■ Sample

Report to Physician

WAUKESHA COUNTY
EXCEPTIONAL EDUCATION COOPERATIVE

PHYSICAL THERAPY **OCCUPATIONAL THERAPY**

Date:

Dear Dr. _____,

Enclosed is the current evaluation report on your patient, _____

_____.

If you have any additional information or areas of concern regarding this child, please contact me at:

_____

_____

Thank you.

Sincerely,

Additional Comments:

Updated Medical Prescription/Referral Request Letter

WAUKESHA COUNTY
EXCEPTIONAL EDUCATION COOPERATIVE

TO: The Parents of _____

FROM:

DATE:

SUBJECT: Updated Medical Prescriptions for the 19___-___ School Year

The rules implementing Subchapter IV of Chapter 115 of the Wisconsin Statutes require that for all students receiving occupational and physical therapy "the district shall obtain an updated medical prescription and information *yearly* or more often if there is a change in the child's physical condition".

All districts participating in the Waukesha County Exceptional Education Cooperative are asking parents to have their children's medical prescriptions updated every summer rather than on the anniversary date of the last prescription obtained. This is being done to improve the efficiency of maintaining the annual therapy prescriptions.

We ask that the prescription be dated between June 15 and August 15 to avoid a prescription expiring during the regular school year. If we do not have a valid prescription on file, we will not offer occupational or physical therapy services to any student. There can be no grace periods.

If you have any questions or concerns on this issue, please feel free to contact Sheryle E. Gavin, Low-Incidence Coordinator, at 785-3900, ext. 46.

Please return the completed medical prescriptions to:

Sheryle E. Gavin
Low-Incidence Coordinator
Waukesha County Exceptional Education Cooperative
2430 North Pilgrim Road
Brookfield, WI 53005

MONTHLY DATA SHEET

The Monthly Data Sheet (see p. 43) is to be completed for the *one* week during the regular school year as specified by the low-incidence office.

Each time block represents 15 minutes of time spent with, or on behalf of, the student named. The time blocks are not used for travel time between schools, therapist preparation time, or lunch breaks. The time blocks are filled in even if a student or therapist is absent.

The number of times seen indicates how many occasions of service were provided, or in case of absence would have been provided, during the representative week.

The District/School column should list the student's district of residence (home district) and the school in which the services are being provided.

The Evaluations section is used for new evaluations of students. The student's name should be listed along with the amount of time and type of activity performed. The activities could include evaluations, observations, multidisciplinary team meetings, and IEP meetings. The student's home district and the school in which the student is currently receiving services should be listed.

Sample ■

Monthly Data Sheet

Month _____ Teacher/Therapist _____

Student's Name	15 Minute Time Blocks	# of Times Seen	District/ School

Evaluations

Student's Name	Time and Type of Activities	District/School

Monthly Mileage Report

Each therapist shall report the mileage driven for job-related travel on a form provided. The form used will depend on which district or agency holds the contract. Generally, mileage will not be paid from home to the first school or from the last school to home. An example of how mileage should be reported is as follows:

Sample Monthly Mileage Report Form

Therapist's Name: _____

Month/Year: _____

Date	From	To	Miles Traveled
2/24	Wisconsin 7.3	Brookside 3.3 Fairview South 4.5 Hillside	15.1
2/25	Admin. Bldg. 4.0	Wisconsin Hills 2.0 Tonawanda	6.0
		TOTAL	21.1

The monthly mileage report is to be sent to the therapist's contracting district after the last day of the month.

The low-incidence coordinator's office will request a copy of a therapist's mileage report if needed.

Add/Delete/Change Form

The Add/Delete/Change (ADC) Form (see p. 45) is used for adding or deleting a student from a therapist's student list, or for changing information that is needed in the low-incidence office to maintain accurate printouts.

Changes in student list information are due in the low-incidence coordinator's office within two weeks of their occurrence.

Sample ■

Add/Delete/Change Form

Waukesha County
Exceptional Education Cooperative

TO: LOW-INCIDENCE COORDINATOR
c/o SCHOOL DISTRICT OF ELMBROOK
2430 NORTH PILGRIM ROAD
BROOKFIELD, WI 53005

Circle: Add Delete Change

From: _____ Effective Date: _____

Service (circle): OT PT HI VI O&M Optacon

PLEASE SUPPLY ALL NECESSARY INFORMATION:

Student's Name _____

Primary EEN (circle) EC MR SDPE PH MH HI VI S/L ED LD

Level of Service (circle) I II III IV

Grade _____

Street _____

City/Zip _____

Phone _____

Date of Birth _____

M-Team Date _____

IEP Date _____

Home District _____

School Attending _____

Staff Change (complete items below):

Add to: _____
Teacher/Therapist

Service (circle) OT PT HI VI O&M Optacon

Delete from: _____
Teacher/Therapist

Service (circle) OT PT HI VI O&M Optacon

Reason for Deletion: _____

_____

LI OFFICE USE ONLY:

LI Secretary _____ IPC _____

Date Rec'd _____ Rec. ID# _____

Annual Report

According to Chapter 115 PI 11.19(9) a-c of the Wisconsin Statutes, "a yearly re-evaluation of the child shall be made".

Forms (see pp. 47-48) are provided by the low-incidence coordinator's office and are to be completed at least annually. During a year that the student is up for a three-year evaluation, however, the therapists can use the Multidisciplinary Team evaluation report as the annual report. Copies of the annual report should be sent to:

- the student's physician
- the programming school
- the programming district
- the student's home district special education office

To provide additional information about a student, the therapist needs only to complete the identifying information on the top of the form and complete only the section that pertains to the additional information being provided. These updates are stapled to the complete annual report.

It is recommended that the annual report be filled out cooperatively between the occupational and physical therapist.

Sample ■

Occupational/Physical Therapists' Annual Report

Per Chapter 115 PI 11.19(9) a-c Statutes

Waukesha County
Exceptional Education Cooperative

	School Year	Date of Report
Name of Student	Date of Birth	Parent or Guardian
Street Address	City	Zip Code
District of Residence	Name of School and District Student Attends	

Prescribing Physician

Physician's Diagnosis:

EXCEPTIONAL EDUCATIONAL SERVICES PROVIDED:

1. General Physical Condition:

2. Developmental Level, Assessments, and Evaluations:

3. Functional Self-Care (ADL) / Adaptive Equipment:

4. Oral Motor/Feeding:

5. Mobility:

6. Communication/General Behavior:

7. Educational Objectives/Progress Toward Independence:

8. Additional Comments:

Level of Service Recommendations (circle):	OT I II III IV	PT I II III IV
Names of Therapists:	Signatures of Therapists:	

Waukesha County
Exceptional Education Cooperative

OT/PT MEMO

TO:

FROM:

DATE:

RE:

[This form is designed as a general memo form to be used to communicate information to a teacher, physician, or parent when a copy is desirable. The form should be printed on NCR paper.]

■ Sample

Recommended Activities Form

WAUKESHA COUNTY
EXCEPTIONAL EDUCATIONAL COOPERATIVE

PHYSICAL THERAPY **OCCUPATIONAL THERAPY**

Recommended Activities

Name: _____ **Date** _____

Therapist: _____

[This form is used for suggested home programs, activities for the classroom teachers, or for the specially designed physical education program. To be printed on NCR paper.]

WAUKESHA COUNTY
EXCEPTIONAL EDUCATIONAL COOPERATIVE

PHYSICAL THERAPY **OCCUPATIONAL THERAPY**

Educational Progress Form

Student's Name: _____ Date: _____

School: _____ Home District: _____

Grade: _____ Teacher: _____

Therapist: _____

Classroom problem areas:

Therapy techniques to support educational goals:

Progress: